ELEVATED HEALTH
1013 West 2700 South
Syracuse, UT 84075
1-801-774-7541

HIPPA Disclosure & Consent

Ketamine Infusion Therapy

To the Patient:

You have the right as a patient to be informed about your condition and the recommended Ketamine Therapy and other procedures to be used so that you may make the decision whether to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of Ketamine Infusions, by Dr. Darin Stettler, and/or other licensed Doctors and Nurses associated with Elevated Health or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for Doctor Stettler. I have had the opportunity to discuss with Dr. Stettler, my diagnosis, the nature and purpose of Depression and other procedures and alternatives. I understand and I am informed that there are some risks to exam and treatment including, but not limited to, drowsiness, changes in perceptions of color or sound, hallucinations, confusion, and delirium, dissociation from body or identity, agitation, difficulty thinking or learning, nausea, dilated pupils and changes in eyesight, inability to control eye movements, involuntary muscle movements and muscle stiffness, slurred speech, numbness, amnesia, slow heartbeat, behavioral changes, increased pressure in the eyes and brain. It can also cause a loss of appetite, upset stomach and vomiting. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and are in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To Be Completed by the Patient:

Print Name: _____

Signature: _____

Date Signed: _____

To be completed by the Patient's Representative (If Necessary): _____

Print Name of Patient: _____

Print name of Patient's Representative: _____

Signature of Patient's Representative: _____ Date: _____

As (Relationship or Authority of Patient's Representative): _____